MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0072-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dr. H, DC

October 6, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Medical Director

CLINICAL HISTORY
Available documentation received and included for review consists of initial and subsequent reports from Dr. H, along with subsequent office/visit notes, three functional capacity evaluation reports, x-ray and MRI reports, surgical and office notes from Dr. T, MD. there is also a Job description provided from BISD.

___ was injured while working for BISD as a custodian. He pulled with this write-off opening date, wrenched his right shoulder. Presented to Dr. H, chiropractor where he underwent extensive conservative treatment. MRI revealed care of the supraspinatus tendon in the rotator cuff with AC joint impingement. The patient subsequently underwent rotator cuff repair and right shoulder open acromioplasty with Dr. T on 5/7/04. This was again followed up with conservative care/rehabilitation with Dr. H. The patient was placed at MMI by Dr. H on 8/5/04 with a 14% whole person impairment comprised of range of motion losses of the right shoulder.

Work hardening has been requested and this has been denied.

REQUESTED SERVICE(S)
Work hardening program X 30 sessions.

DECISION
Denied. There is no establishment of medical necessity for work hardening services.

RATIONALE/BASIS FOR DECISION
Work hardening is involves a multidisciplinary approach and is reserved typically for outliers of the normal patient population, i.e. poor responders to conventional treatment intervention, with significant psychosocial issues and extensive absence from work.

The sustained injury appears to have been a relatively straightforward cuff tear which responded reasonably well to a surgical repair and conservative physical intervention. According to the available documentation, this patient's continued problems were limited to

strength and mobility loss, associated with his shoulder injury. No other complicating factors or barriers to recovery are reported or recognized to suggest anything more that the requirement of a focused strengthening/rehabilitation program was necessary.

There is minimal indication of psychosocial involvement. The patient did undergo a mental health evaluation which stated that the patient was an appropriate candidate for work hardening although no objectively identified factors for significant psychosocial involvement suggesting the requirement for work hardening were identified. In fact, the converse situation seemed to be more prevalent.

All of the other indicators which would normally identify an appropriate candidate, namely the functional capacity evaluations, pain diagrams and reports of treatment participation, indicate that the patient does not require any form of multi-disciplinary work hardening. The FCE's showed patient participation to be valid, with only focal identified weakness to the shoulder identified as abnormal (which would be expected in such a patient). Poor/invalid participation with submaximal effort or a mixed picture of effort/participation would generally indicate the requirement for additional intensive treatment provided by work hardening. The numeric and visual analog scales reported are appropriate to describe symptoms, and do not suggest any symptom exaggeration. Both of the scales would ordinarily show exaggerated symptomatic responses in order for work hardening to be appropriate.

The patient appears to be fairly close to the physical demand category level required by his work at this point. The available job description describes the critical demands as requiring frequent lifting of between 10-35 lbs., "regularly" lift or move up to 50 lbs. and occasional lift/move 100 lbs. Aside from the requirement of occasional moving/lifting of 100 lbs., the job duties full well within the medium physical demand level category. The patient has demonstrated the ability to perform all requirements aside from the 100lb lift. The job description provides that "reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions".

Considering the nature of the diagnosis, it is doubtful that he will reach a heavy physical demand level of function as required by the 100lb lift identified. Even if appropriate entry criteria were present, the overall benefit of a work hardening environment is suspect. With appropriate return to work limitations, returning this patient to work would, I

believe, be the best continued "work hardening" for this patient.

References:

1/ CARF Manual for Accrediting Work Hardening Programs

2/ AMA Guides to the Evaluation of Physical Impairment, 4th Edition

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 8th day of October, 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: